

Ramirez v Mastrangelo

2008 NY Slip Op 33255(U)

November 21, 2008

Supreme Court, Nassau County

Docket Number: 15228/06

Judge: Kenneth A. Davis

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SCW

SHORT FORM ORDER

SUPREME COURT - STATE OF NEW YORK

Present: HON. KENNETH A. DAVIS,
Justice

TRIAL/IAS, PART 3
NASSAU COUNTY

LIGIA RAMIREZ,

Plaintiff,

SUBMISSION DATE: 10/17/008
INDEX No.: 15228/06

-against-

MICHAEL MASTRANGELO and M.J.
MASTRANGELO,

MOTION SEQUENCE # 1

Defendants.

The following papers read on this motion:

- Notice of Motion/ Order to Show Cause..... X
- Answering Papers..... X
- Reply..... X
- Briefs: Plaintiff's/Petitioner's.....
- Defendant's/Respondent's.....

Motion by defendants, Michael Mastrangelo and M.J. Mastrangelo, for an Order of this Court, awarding them summary judgment and dismissing the complaint of the plaintiff, Ligia Ramirez, on the grounds that she has not satisfied the "serious injury" threshold requirement of Insurance Law §5102(d) is granted.

Plaintiff, Ligia Ramirez, seeks to recover damages for injuries that she allegedly sustained on October 14, 2003 at approximately 1:15 p.m. near the intersection of Willis Avenue and Winthrop Street in Williston Park, New York. Plaintiff was the driver of a PT Cruiser that she alleges was struck in the rear by a vehicle owned by defendant, Michael Mastrangelo and being operated by defendant, M.J. Mastrangelo. This impact occurred as she was stopped for a red light behind another vehicle. Plaintiff claims that as a result of this initial impact, she was pushed forward into the vehicle stopped in front of her at the red light.

Defendants move for summary judgment dismissal of plaintiff's complaint on the grounds that she has not satisfied the "serious injury" threshold of Insurance Law §5102(d).

Plaintiff, 53 years old at the time of her accident, claims that as a result of the subject accident, she sustained: disc herniation

at the C3-4 level of the cervical spine resulting in narrowing of the ventral CSF space; disc herniation at the C4-5 level of the cervical spine resulting in narrowing of the ventral CSF space; disc herniation at the C5-6 level of the cervical spine resulting in narrowing of the ventral CSF space; subluxation of the cervical spine; and impingement of the left shoulder (*Verified Bill of Particulars*, ¶5).

Plaintiff contends that the injuries she sustained fall within only two of the nine categories of the "serious injury" statute: "significant limitation of use of a body function or system;" and "a medically determined injury or impairment of a non-permanent nature which prevents the injured person from performing substantially all of the material acts which constitute such person's usual and customary daily activities for not less than ninety days during the one hundred eighty days immediately following the occurrence of the injury or impairment" (*Motion*, Ex. A, ¶19; Ex. B, ¶19).

Plaintiff does not claim that her injuries fall under any other category of Insurance Law 5102(d). Thus, any other category of serious injury other than these alleged will not be considered by this Court herein (*Melino v. Lauster*, 195 AD2d 653, 656 [3rd Dept. 1993] *affd* 82 NY2d 828 [1993]). Whether she can demonstrate the existence of a compensable serious injury depends upon the quality, quantity and credibility of admissible evidence (*Manrique v. Warsaw Woolen Associates, Inc.*, 297 AD2d 519 [1st Dept. 2002]).

In support of their motion, defendants submit, *inter alia*, the unsworn, unaffirmed electrodiagnostic studies performed by Dr. Christopher Burrei on July 13, 2004; the sworn and affirmed report of Dr. John C. Killian, M.D., an orthopedist, who performed an independent orthopedic examination of the plaintiff on February 1, 2008; the sworn and affirmed report of Dr. Steven Ender, D.O., a neurologist who performed an independent neurological examination of the plaintiff on December 13, 2007; and the sworn and affirmed report of Dr. David A. Fisher, M.D., a board certified radiologist, who performed an independent examination of the plaintiff on October 26, 2007.

The electrodiagnostic studies are neither sworn to nor affirmed to be true under penalty of perjury, and therefore do not constitute competent evidence. Accordingly said report will not be considered by this Court on the instant motion (*Mezentseff v. Lau*, 284 AD2d 379 [2nd Dept. 2001]; *Meric v. Cancela*, 275 AD2d 309 [2nd Dept. 2000]).

Dr. Killian's independent orthopedic examination, concludes, in pertinent part, as follows:

CERVICAL SPINE:

On inspection the normal cervical lordosis was maintained without visible evidence of atrophy, asymmetry, deformity or muscle spasm. Her head was held in a normal attitude and her shoulders were level. On palpation she complained of tenderness in the midline of the cervical spine and she complained of left-sided lower cervical paraspinal tenderness extending into the left trapezius. There was no palpable muscle spasm or deformity. **The range of motion of her cervical spine was tested (by visual observation)** and it was found that flexion and extension were full at 45 degrees (normal 45 degrees), right and left rotation were full at 90 degrees (normal 90 degrees) and right and left lateral flexion were full at 45 degrees (normal 45 degrees). She complained of pain at all extremes of cervical motion, especially with left rotation and left lateral flexion. There was no muscle spasm.

LEFT SHOULDER:

On inspection the normal bony and soft tissue contours of her left shoulder were maintained **without visible evidence** of atrophy, asymmetry, deformity, swelling or discoloration. On palpation she complained of tenderness over the left trapezius extending across the deltoid down to the anterior subacromial region but *there was palpable swelling or deformity*. **The range of motion of her shoulder was tested (by visual observation)** and found to be full and symmetrical with the right shoulder with external rotation to 70 degrees (normal 70 degrees), internal rotation to allow her to bring both hands symmetrically a distance of 6" to 8" off of her buttocks (normal 6" to 8") and forward flexion to 180 degrees (normal 180 degrees). She complained of pain in the left shoulder with full forward flexion but she did not complain of pain with the other motions. There was no weakness in external rotation. She did not complain of pain with impingement testing but there was mild clicking in the subacromial space with rotation the shoulder in the abducted position although similar clicking could be elicited in the right shoulder. There was no instability on anterior anticipation testing.

OPINION:

Based on the available history and medical documentation I would conclude that Ms. Ramirez was treated for complaints of pain in the neck and left shoulder region after the 10/4/03 accident. She was eventually referred for MRIs. The cervical MRI was described as showing central disc herniations at

three levels, although there is no description of any neurological compromise. Those types of changes are commonly seen incidentally in individuals her age and are of questionable clinical significance. That study should be reviewed by an independent radiologist to verify the interpretation and comment on the significance of the findings. She was sent for an MRI of her left shoulder which was negative. She went to an orthopedic surgeon who felt that there were findings suggestive of peripheral nerve entrapments in various areas in her upper extremities although EMGs and nerve conduction studies were normal. She continues to complain of pain in the neck and left shoulder region.

The physical examination was remarkable for complaints of tenderness and complaints of pain with various motions which were unaccompanied by objective findings including restriction motion or muscle spasm. The neurological examination was normal. There was no atrophy to indicate disuse. The shoulder examination was remarkable for subjective complaints of tenderness and pain which were not accompanied by objective findings.

Based on this examination I would conclude that Ms. Ramirez has fully recovered from any problems with her neck and left shoulder region for which she was treated after this accident. There was no objective evidence of any residual impairment of those regions or any disability from injuries to those areas from this accident. She requires no further orthopedic evaluation, follow-up or treatment for injuries from this accident. She is capable of working at her normal capacity and performing all of her usual activities of daily living without limitations due to impairments caused by injuries from this accident (*Motion, Ex. F [Emphasis Added]*).

Dr. Ender's independent neurological examination, concludes, in pertinent part, as follows:

Musculoskeletal Examination:

Neck: To my eye there is full range of motion of the cervical spine. Lateral rotation was performed to 90 degrees bilaterally (90 degrees being normal). Flexion/extension was full to 45 degrees (45 degrees being normal). The claimant has complaints of tenderness in the trapezius musculature. There is no cervical paraspinal muscle or trapezius muscle spasm. Back: Straight leg raising is negative in the seated position. The claimant can flex her lumbar spine to 90 degrees (90 degree bing normal). *There was lumbosacral paraspinal or sciatic notch tenderness.* There is no lumbosacral paraspinal muscle spasm.

Impression:

Resolved cervical paraspinal muscle strain. *If Mrs. Ramirez's history and medical records are accurate as described then a causal relationship between her accident and injuries has been established.* Mrs. Ramirez has a normal neurological examination. I find no objective neurological abnormalities to indicate any neurological disability. She can continue with her current activities of daily living and working without restrictions (Motion, Ex. G [Emphasis Added]).

Finally, Dr. Fisher's review of the radiology films concerning the plaintiff's left shoulder and cervical spine, taken approximately 6 months following the date of the accident conclude, in pertinent part, as follows:

MRI of the Left Shoulder (MR Imaging at Garden City 4/10/04):

* * *

Impression:

Mild bony impingement secondary to acromioclavicular hypertrophic changes.

SUMMARY:

...This study shows hypertrophic spurring at the acromioclavicular joint with resultant impingement. In my opinion, these degenerative changes are consistent with a preexisting condition. The rotator cuff and labrum appear intact. There is no radiographic evidence of recent traumatic or causally related injury to the left shoulder.

MRI of the Cervical Spine (MR Imaging at Garden City 3/20/04):

* * *

Impression:

Diffuse degenerative changes, most pronounced at the C5/6 level.

SUMMARY:

There is clear evidence of degenerative changes throughout the cervical spine, most pronounced at the C5/6 level. These changes are consistent with a preexisting condition. The small disc protrusion at C4/5 and the mild disc bulge at C5/6 are compatible with the amount of degenerative change present. There is no radiographic evidence of traumatic or causally related injury to the cervical spine.

While Dr. Killian and Dr. Ender's affirmations fall short of constituting objective medical evidence, defendants' proof nevertheless establishes defendants' prima facie case for serious injury under the "significant limitation of use of a body function or system" category of Insurance Law §5102(d). Specifically, in the absence of objective medical testing by Dr. Killian and Dr. Ender,

their impressions and opinions that plaintiff did not sustain a serious injury within the meaning of the statute are herewith dismissed. Neither physician sets forth the objective medical testing he performed to support his respective conclusion; rather, Dr. Killian and Dr. Ender, both rely upon their "eye" and "visual observations" to quantify the range of motion measurements of plaintiff's cervical spine, neck and left shoulder (*Vasquez v. Basso*, 27 AD3d 728 [2nd Dept. 2006]; *Walters v. Papanastassiou*, 31 AD3d 439 [2nd Dept. 2006]). This is clearly insufficient.

Defendants' final medical submission, however, is the affirmed radiological report of Dr. Fisher who acknowledges therein that "[t]here is mild impingement secondary to acromioclavicular hypertrophic spurring" in plaintiff's left shoulder and "disc dehydration, disc space narrowing and uncovertebral spurring (spondylosis)" and "[a]t C4/5 there is a small posterior central disc protrusion and at C5/6 there is mild disc bulge" (*Motion*, Ex. H). Defendants' reliance upon Dr. Fisher's report establishes their prima facie case for summary judgment thereby shifting the burden to the plaintiff. A diagnosis of a herniated or bulging disc, without more, is not evidence of a serious injury (*Toure v. Avis Rent A Car Systems, Inc.*, 98 NY2d 345 [2002]). If plaintiff claims to have suffered a herniated discs, he must, in addition to submitting medical proof of the injury, submit objective evidence as to the duration, extent or degree of the alleged physical limitations attributed to the disc injury (*Descovich v. Blieka*, 279 AD2d 499 [2nd Dept. 2001]). Mild sprains to the lumbar and cervical spine are insignificant and as a matter of law, do not constitute a serious injury (*Lebron v. Camacho*, 251 AD2d 295 [2nd Dept. 1998]; *Rhind v. Naylor*, 187 AD2d 498 [2nd Dept. 1992]).

In opposing defendants' motion, plaintiff submits, *inter alia*, her own affidavit; the sworn and notarized affidavit of Christopher Bogdan, D.C., a chiropractor; and the unsworn and unaffirmed MRI reports of the plaintiff's cervical spine dated 3/30/04 and of her left shoulder dated 4/10/04. It is noted at the outset that while chiropractor Christopher Bogdan's affidavit is admissible under the guidelines of the CPLR (CPLR 2106; see also *Pichardo v. Blum*, 267 AD2d 441 [2nd Dept. 1999]), and while his affidavit sets forth range of motion findings with respect of plaintiff's cervical spine, and notes limitations in her spine based on an objective examination of the plaintiff on May 26, 2007, more than three and a half years after the date of the accident, the plaintiff fails to proffer any competent medical evidence showing *initial* range of motion limitations in her spine that were contemporaneous with the subject accident (*Li v. Yun*, 27 AD3d 624 [2nd Dept. 2006]; *Bell v. Rameau*, 29 AD3d 839 [2nd Dept. 2006]).

Plaintiff has also failed to provide, as required, objective evidence of the extent or degree of the alleged physical limitation

resulting from a disc injury and its duration (*Diaz v. Turner*, 306 AD2d 241 [2nd Dept. 2003]). Despite the existence of MRIs indicating disc protrusions and herniations, plaintiff has failed to rebut defendants' prima facie showing that she did not sustain a serious injury under Insurance Law 5102(d) because there is no objective demonstration of a significant impairment related thereto (*Kearse v. NYCTA*, 16 AD3d 45 [2nd Dept. 2005]).

Taken together, it is clear from plaintiff's proof that the plaintiff's restrictions of movement in her cervical spine and left shoulder were only slight, minor or mild. Plaintiff has failed to thus establish that she sustained a "significant limitation of use of a body function or system" (*Toure v. Avis Rent A Car Sys.*, 98 NY2d 345, 353 [2002]). The limited medical records all suggest soft tissue, non permanent injuries of either sprains or strains. They do not indicate a serious injury as defined in the Insurance Law.

Finally, plaintiff's deposition testimony confirms that she was not prevented from performing substantially all other daily activities during 90 days following the occurrence of this accident. At her deposition, plaintiff stated that at the time of her accident, she was employed as a branch manager at the Washington Mutual bank in Hewlett. She stated that while she did not miss any full days from work as a result of this accident, she "would leave early many days to go for treatment" (*Ramirez Tr.*, p. 48). She stated that as a result of this accident, there is nothing she can no longer do. However, she has difficulty vacuuming and looking over her shoulder when driving. Since the plaintiff acknowledges that she only missed a few *half* days and did not miss any fully days from work as a result of this accident, she has failed to establish a *prima facie* case that she sustained a medically-determined injury or impairment of a nonpermanent nature which prevented her from performing substantially all of the material acts which constituted her usual and customary daily activities for not less than 90 days during the 180 days immediately following the occurrence of the injury (*Letellier v. Walker*, 222 AD2d 658 [2nd Dept. 1995]).

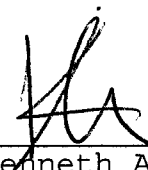
Moreover, in her affidavit in opposition to defendants' motion, plaintiff's only statement in regards to her limitation of activities is, as follows: "After my accident of October 4, 2003, I can no longer... perform activities that require extensive bending, lifting, muscle strength and flexibility, which, I cannot do because of the pain, limitations and restrictions I now have as a result of the injuries I sustained. I have difficulty cleaning my home, driving my car and sitting or standing for extended periods of time." However, in the absence of any documentation in evidentiary form to prove that such curtailment of activities was at the direction of a doctor and thus medically determined (*cf. Nelson v. Distant*, 308 AD2d 338 [1st Dept. 2003]), plaintiff's

self-serving affidavit is insufficient to establish a serious injury within the meaning of Insurance Law §5102(d) (*Glielmi v. Banner*, 254 AD2d 255 [2nd Dept. 1998]; *Rum v. Pam Transport, Inc.*, 250 AD2d 751 [2nd Dept. 1998]). Plaintiff's own recitation of treatment has no evidentiary value. Subjective evidence or complaints of limitations unsupported by credible medical evidence or documentation is not enough to establish the threshold issue of serious injury (*Ackerson v. Mincy*, 162 AD2d 934 [3rd Dept. 1990]). Furthermore, there is no proof of continuous confinement, total loss of mobility or substantive disability which prevented the plaintiff from engaging in all customary and usual daily activities (*Hezekian v. Williams*, 81 AD2d 261 [2nd Dept. 1981]). Thus, plaintiff's 90/180 day "serious injury" claim must also be dismissed.

Defendants' motions for summary judgment dismissal of plaintiff, Ligia Ramirez's complaint on the grounds that plaintiff has not satisfied the "serious injury" threshold requirement of Insurance Law §5102(d) is granted.

Settle Judgment on Notice.

Dated: NOV 21 2008



Kenneth A. Davis, J.S.C.

ENTERED
NOV 25 2008
NASSAU COUNTY
COUNTY CLERK'S OFFICE